# Advance Care Planning General Practice Guidelines

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## Purpose:

1. To inform clinicians regarding advance care planning requirements and its role in consent for medical treatment according to the *Medical Treatment Planning and Decisions Act 2016*.
2. To inform clinicians of their role and responsibilities to optimise the delivery of person-centred care.

## Background:

Advance care planning is a process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their decisions.

People accessing health services may have advance care planning documentation to share, and they should have the opportunity to participate in advance care planning if they choose to.

The Medical Treatment Planning and Decisions Act 2016 outlines the requirements of clinicians when treating people who do not have decision-making capacity. Advance care planning documentation assists the consent process for people that lack capacity.

## Overview of the Medical Treatment Planning and Decisions Act 2016

The Medical Treatment Planning and Decisions Act 2016:

- gives statutory recognition to Advance Care Directives and establishes a single framework for medical treatment decision making for people without capacity, ensuring people receive treatment consistent with their preferences and values.
- is part of a broader shift towards empowering people to make their own treatment decisions. This includes clear recognition that, wherever possible, people should be supported in making their own decisions.
- replaces most of the medical treatment provisions in the Guardianship and Administration Act 1986.
- repeals the Medical Treatment Act 1988 (no new Refusal of Treatment Certificates or Medical Enduring Power of Attorney documents).
- introduces a new Medical Treatment Decision Maker hierarchy with new Appointment of Medical Treatment Decision Maker document.
- introduces a new Medical Support Person role with relevant documentation.
- changes the responsibilities of clinicians in the consenting process for people who do not have capacity and introduces new definitions of "routine" vs "significant" medical treatment and includes consent for pharmaceuticals.

Competent paediatric patients can write an Advance Care Directive and appoint a Medical Support Person if at least one of the witnesses is a registered medical practitioner or psychologist with the prescribed training and experience.

## Definitions:

**Advance Care Planning (ACP):** The process whereby persons, in consultation with health care providers, family members and important others, make decisions about their future health care should they become incapable of participating in medical treatment decisions. ACP assists with the documentation of these wishes and ensures that they are identifiable and available to clinicians at a time when these medical treatment decisions need to be made

**Adult**: a person of or above the age of 18 years.

**Capacity:** to have decision-making capacity, a person must be able to:

a. Understand the information relevant to the decision and the effect of the decision;
b. Retain that information to the extent necessary to make the decision;
c. Use or weigh that information as part of the process of making the decision; and
d. Communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

**Emergency Treatment**: a health practitioner may administer **medical treatment** without consent if the practitioner believes the medical treatment is necessary, as a matter of urgency to:

- Save the person's life
- Prevent serious damage to the person's health
- Prevent the person from suffering or continuing to suffer significant pain or distress

The health practitioner is not permitted to administer medical treatment to a person if they are aware the person has refused the particular treatment in a valid Instructional Advance Care Directive. The Instructional Advance Care Directive must be readily available for this to occur.

**Instructional Advance Care Directive**: a statement of a person's medical treatment decision that is directed to that person's health practitioners. It takes effect when the person loses decision-making capacity, and will apply as though the person has consented or refused the treatment. It is legally binding and it is unprofessional conduct to knowingly disobey an Instructional Advance Care Directive. The scope includes physical illness and mental illness. A **Refusal of Treatment Certificate** written prior to 12 March 2018 is considered an Instructional Advance Care Directive. Both an Advance Care Directive and Advance Statement may need to be considered for those admitted for treatment of a mental illness who do not have decision-making capacity but are not receiving treatment under the *Mental Health Act 2014.*

**Interstate Advance Care Directives** are considered Values Advance Care Directives in Victoria.

**Medical Treatment**: The treatment must be for one or more of the purposes listed below, and must be one of the forms of treatment listed below.

| Purpose | Treatment |
|---|---|
| • diagnosing a physical or mental condition<br>• preventing disease<br>• restoring or replacing bodily function in the face of disease or injury<br>• improving comfort and quality of life | • treatment with physical or surgical therapy<br>• treatment for mental illness<br>• treatment with<br>➢ prescription pharmaceuticals<br>➢ an approved medicinal cannabis product<br>• dental treatment<br>• palliative care |

**Medical Treatment Decision Maker (MTDM)**: makes medical treatment decisions on behalf of a person who does not have decision-making capacity, and may consent or refuse medical treatment on behalf of the person. This person may be appointed in writing, or allocated according to the MTDM hierarchy (see below). At any one time, there will only be one MTDM. This ensures it is clear who is responsible for making the medical treatment decisions. There is a hierarchy for determining the person's medical treatment decision maker, and the first available and willing person from the list below will be the MTDM.

**MTDM hierarchy:**

- an appointed medical treatment decision maker*;
- a guardian appointed by VCAT to make decisions about the person's medical treatment;
- the first of the following with a close and continuing relationship with the person:
    - the spouse or domestic partner;
    - the primary carer of the person;
    - the oldest adult child of the person;
    - the oldest parent of the person;
    - the oldest adult sibling of the person.

*An **Enduring Power of Attorney (Medical Treatment)** written prior to 12 March 2018, **Enduring Power of Attorney (Personal Matters)** written between September 2015 and 11 March 2018, an **Enduring Power of Guardianship** written prior to 1 September 2015, and a **valid interstate appointment of a substitute decision maker** for medical treatment decisions are considered an appointed MTDM.

If a MTDM consents to treatment, a health practitioner may proceed with that treatment. If the MTDM refuses treatment, a health practitioner cannot provide that treatment.

Should none of the above be willing and available, the Office of the Public Advocate must be contacted (via the completion of a Section 63 on-line) before proceeding with significant treatment if it is not an emergency (phone 1300 309 337).

The MTDM may access relevant medical records to make a properly informed decision. This is the only circumstance in which a MTDM may access a person's medical record.

**Routine Treatment** is any medical treatment other than significant treatment.

**Significant Treatment** is any medical treatment of a person that involves any of the following:

- A significant degree of bodily intrusion
- A significant risk to the person
- Significant side effects
- Significant distress to the person

The Department of Health and Human Services have developed a guideline outlining examples of significant treatment.

For further information:

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/medical-treatment-planning-and-decisions-act.

**Support Person**: supports a person to make their own decisions and to help ensure these decisions are enacted. They may collect and collate information from the medical record to help inform medical treatment decisions. The Support Person and the MTDM may be the same person.

Please note, the Support Person is not the same as a 'Nominated Person' (see Nominated Person Practice Guideline) whose role takes effect once a person is being treated in accordance with the *Mental Health Act 2014*.

**Values Advance Care Directive**: a statement of a person's preferences and values as the basis on which they would like any medical treatment decisions to be made on their behalf. It must be considered by the health professional when offering medical treatment, and the Medical Treatment Decision Maker when making medical treatment decisions for that person. Documents written prior to 12 March 2018 such as Advance Care Directives or Advance Care Plans are considered Values Advance Care Directives.

**Table 1. Terminology for Advance Care Planning**

| **Previous Terminology** | ***Medical Treatment Planning and Decisions Act 2016* Terminology** |
|---|---|
| Refusal of Treatment Certificate | Instructional Advance Care Directive |
| Advance Care Directive **or**<br>Advance Care Plan **or**<br>Statement of Choices | Values Advance Care Directive |
| Enduring Power of Attorney (Medical Treatment) **or**<br>Enduring Power of Attorney (Personal Matters) written between September 2015 and 11 March 2018 **or**<br>Enduring Power of Guardianship written prior to 1 September 2015 | Appointed Medical Treatment Decision Maker |

## Policy

1. All registered health practitioners are obliged to make reasonable efforts in circumstances to ascertain whether a person (who does not have capacity to make their own decisions) has either or both an Advance Care Directive or Medical Treatment Decision Maker.
   All patients will be asked on first presentation (via admission paperwork) if they have any of the following documents:
   - Advance Care Directive
   - Appointment of Medical Treatment Decision Maker (may also be Medical Enduring Power of Attorney form, Enduring Power of Attorney for personal matters both used until 11th March 2018 or an Enduring Guardianship form used until 31st August 2015)
   - Appointment of a Support Person
   - Refusal of Treatment Certificate (used until 11th March 2018)

2. If a health practitioner is aware of an Advance Care Directive (Instructional directive) they must comply with it – except in very limited circumstances

3. Medical Practitioners have particular responsibilities as authorised witnesses to the completion of Advance Care Directives

4. A health care professional must consider that all Advance Care Plans are valid (that is, in the absence of evidence otherwise, an Advance Care Plan was completed by a competent adult without coercion)

5. All ACP documents must be referenced in the medical alert system. These documents include:
   - Advance Care Directive for adults
   - Appointment of Medical Treatment Decision Maker
   - Appointment of a Support Person

6. Any ACP documents developed are recommended to be communicated with the local hospital

## Promotion and engaging patients

Building ACP into core business is essential to make sure all patients are offered the opportunity to participate, and sustainability of ACP. It is also important to reassure patients that ACP is part of everyone's healthcare and therefore 'normal practice'.

Posters and information brochures should be available in waiting areas. Appendix 1 are the posters provided by Department of Health and Human Services (DHHS) and are available in hard copy free of charge or in electronic format – email: acp@dhhs.vic.gov.au

Appendix 2 is an example patient information brochure which is available in electronic format – e-mail acp@bendigohealth.org.au

## Identify if there are existing Advance Care Planning documents

When a patient first presents to the clinic it is important to ask of the existence of ACP documentation in your admission paperwork*. Include the following questions:

- Do you have an appointed Medical Treatment Decision Maker (this may be a Medical Enduring Power of Attorney document)?
- Do you have an Advance Care Directive or Advance Care Plan?
- If you answered 'yes' to either of the above questions please provide us a certified copy or bring in your original documents.

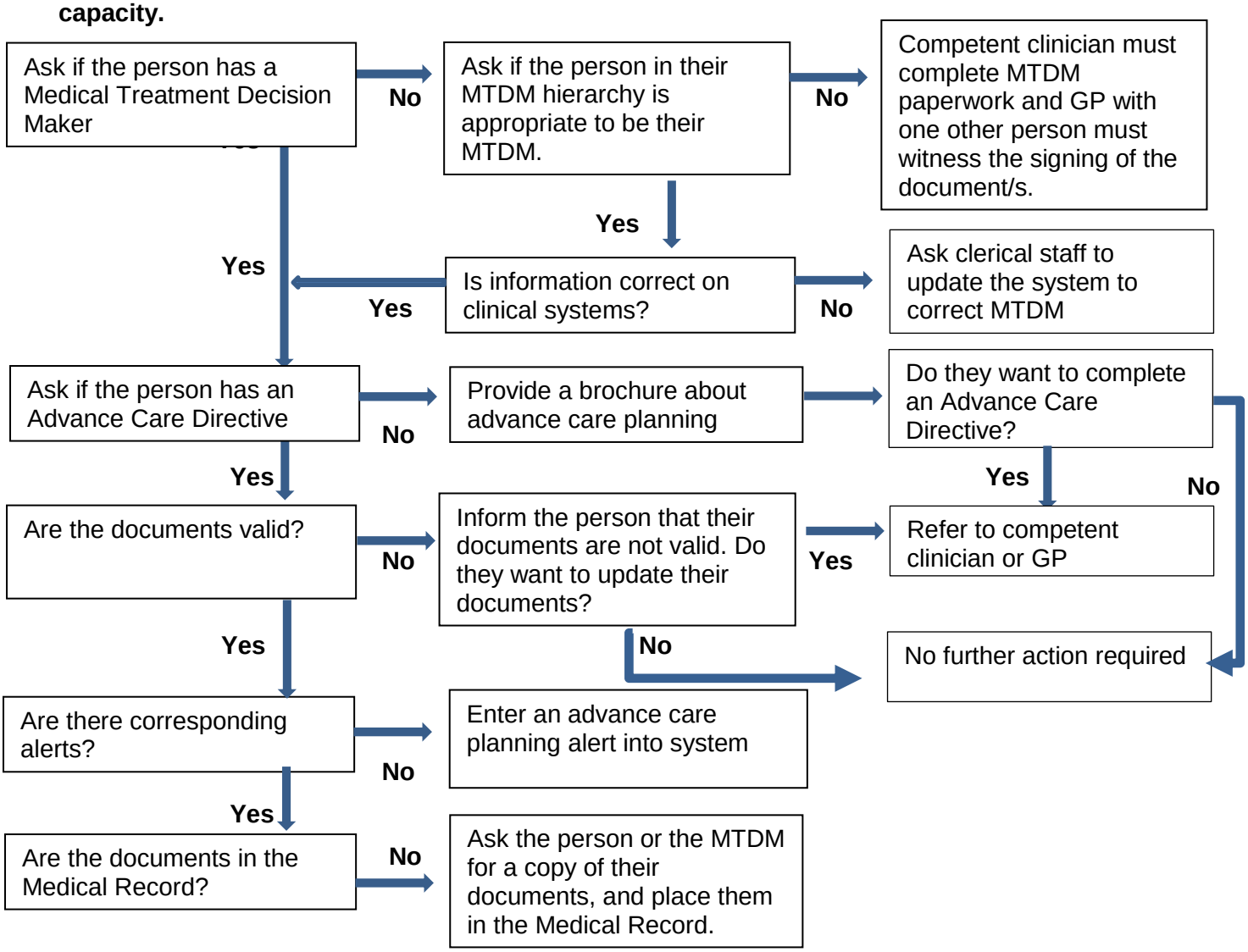
During the consultation to clarify this information you may ask (see Figure 1):

- "Do you have an Advance Care Directive", or 'Have you ever written down your goals, values and beliefs or your preferences about specific medical treatment in case you become seriously ill or unable to make your own decisions?"

If the patient does present documents a clinician must check:

- Are the person's documents valid?
- If the person wants to make any changes to their Advance Care Planning document arrange a further discussion if required.
- Are the appropriate alerts on the system? If not, update them.
- Ensure the copy of the document is then entered into person's medical record.

**Figure 1: Advance Care Planning responsibilities in initial assessment of a patient with capacity.**




*A summary of current DHHS document templates is available in Appendix 3.

## MBS items that can support ACP

This section describes how Medicare Benefits Schedule (MBS) Item numbers may be used by GPs for Advance Care Planning where clinically appropriate. For example existing terminal illness or chronic disease with potential to impact on the duration and/or quality of life, or when it is requested by the patient.

Note:

- There is no dedicated MBS Item for Advance Care Planning.
- The GP must ensure that the requirements for the services, as set out in the MBS, are met (http://www.mbsonline.gov.au). This information is current at June 2017.
- The time required to undertake a general attendance in consulting rooms or a residential aged care facility (RACF) or a Health Assessment service may only include the activities described in the *Health Insurance (General Medical Services Table) Regulations 2018*. Any aspects of an Advance Care Plan that are not covered by the requirements of the Regulations may not be included in the time taken to provide the service.
- MBS Items 701, 703, 705, 707 and 715 (Health Assessments) must be provided by a GP personally attending a patient. Suitably qualified health professionals, such as general practice nurses, Aboriginal and Torres Strait Islander health practitioners, and Aboriginal health workers, may assist GPs in performing Health Assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the GP. This may include activities associated with information collection and providing patients with information about recommended interventions.

| ITEM TYPE | MBS ITEM NUMBER | COMMENTS |
|---|---|---|
| **General Consultations** (Level A–D)<br>**A** Simple<br>**B** <20 mins<br>**C** 20–39 mins<br>**D** At least 40 mins | The appropriate item numbers for levels A-D apply as follows:<br>**Location**<br>• GP consulting rooms<br>• RACF<br>• Place other than consulting rooms or RACF<br>Note: If ACP constitutes part of an afterhours consultation it is important to make an 'exceptional circumstances' notation in your clinical records. | A Level B, C or D consultation must include any of the following activities that are clinically relevant:<br>a) taking a (C – detailed, D – extensive) patient history<br>b) performing a clinical examination<br>c) arranging any necessary investigation(s)<br>d) implementing a management plan<br>e) providing appropriate preventive health care, in relation to one or more health-related issues, with appropriate documentation.<br>Advance Care Directives will usually involve a discussion of medical conditions, prognosis, management options, and planning ahead for future care needs.<br>Advance Care Plans may be completed over a number of short consults or may require long consult/s such as Level C or D.<br>In addition, although short for most Advance Care Planning activities, at times, the Level A consultation may be appropriate, for example, to conclude discussions and complete documentation. |

| | | |
|---|---|---|
| **Health Assessments** (time-based)<br>(including for people aged 75+) | 701 Simple; <30 mins<br>703 Standard; not complex; 30–45 mins<br>705 Long; needing in-depth consideration and strategies; 45–60 mins<br>707 Prolonged; complex patient with significant long-term health issues; 60+ mins<br>**Frequency:** for the Health Assessment for People Aged 75 years and older – not more than once in a 12-month period.<br>**Frequency:** for the Comprehensive Medical Assessment (CMA) of Permanent Residents of Residential Aged Care Facilities (RACF) – on admission to the RACF, provided that a comprehensive medical assessment has not already been provided in another RACF within the previous 12 months, and at 12-month intervals thereafter. | A Health Assessment must include the following elements:<br>• information collection, including taking a patient history and undertaking or arranging examinations and investigations as required<br>• making an overall assessment of the patient<br>• recommending appropriate interventions<br>• providing advice and information to the patient<br>• keeping a record of the Health Assessment, and offering the patient a written report about the Health Assessment, with recommendations about matters covered by the Health Assessment, and<br>• offering the patient's carer a copy of the report or extracts of the report relevant to the carer.<br>Consider addressing Advance Care Planning as part of a Health Assessment for people aged 75+. As this Health Assessment must include the activities as listed above, there may not be time to complete all Advance Care Planning activities, however, as an example, it may be possible to offer printed information and a follow-up consultation. |
| **Chronic Disease Management** | Patients in the community 721,723,729,732<br>Patient in RACF 731<br>Practice nurse or Aboriginal health practitioner monitoring of a care plan 10997 | Including ACP in chronic disease management discussions promotes collaborative decisions with patients and allows these to be shared with other health care providers. |
| **Aboriginal and Torres Strait Islander Peoples Health Assessment(for people aged 0–14, 15–54, and 55+)** | 715 (not time-based)<br>Frequency: not more than once in a 9-month period | In relation to item 715, in addition to specific requirements of the three age cohorts (0–14, 15–54, and 55+), an Aboriginal and Torres Strait Islander Peoples Health Assessment must include the elements outlined above. |
| **Case Conferencing** | Patients in the community and RACF:<br>GP organises and coordinates:<br>735, 739, 743<br>GP participates:<br>747, 750, 758 | May include pain management and palliative care specialists |

**Practice nurse incentive program (PNIP)**
Nurses and Aboriginal health practitioners can provide ACP support, follow-up and interventions under PNIP funding.

For more detailed information about MBS item descriptors and explanatory notes visit MBS online http://www.mbsonline.gov.au or phone the Department of Human Services (Medicare) provider enquiry line on 132 150.

## Triggers for introducing ACP

These time points identify where discussion of ACP may fit as part of routine care. The practitioner can include prompts in the appointment reminders and initiate discussions during these key visits.


**New admission:**

- ensure you ask in your admission paperwork – do you have a MTDM or ACD and if so please provide a certified copy

**Person related:**

- if it is raised by the person / family
- if the person has limited support people
- if conflict in decision-making is anticipated
- if the person has a carer
- is a resident of, or is about to enter, an aged care facility
- if the person is at risk of losing capacity e.g. early dementia

**Disease related:**

- if the person has a new or significant diagnosis (e.g. metastatic disease, transient ischemic attack)
- if the chronic illness is advanced (e.g. COPD, heart failure)
- if the disease will cause loss of capacity e.g. early dementia
- at a key point in the disease pathway e.g. after discharge from hospital

**Prognosis related:**

- life limiting illness (e.g. dementia or advanced cancer)
- if you answer 'yes" to the 12 month surprise question or if another prognostic tool such as SPICT (Supportive and Palliative Care Indicators tool) indicates risk of deterioration
- if the person is about to enter a residential aged care setting
- if the disease is life limiting
- if the person is aged 75 or older, or if Aboriginal or Torres Strait Islander aged over 55 years

## Determine if the patient has a Support Person

The MTPD Act 2016 introduced the role of the support person. If one has already been appointed ensure a certified copy of the document is available in your patient's medical file.

If the patient has not appointed a support person information and documents are available from the DHHS website:

- Checklist of steps for appointing your support person (medical treatment)
- Appointment of support person form
- Appointment of support person for someone signing on your behalf

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms

## Determine the patient's MTDM

It is the responsibility of all clinicians to ascertain who a person's MTDM is. The MTPD Act 2016 establishes the legal hierarchy of who becomes the person's MTDM once the patient has lost capacity according to the following list:

1. Appointed MTDM
2. Guardian appointed by VCAT under the Guardianship and Administration Act 1986 (with power under that appointment to make medical treatment decisions on behalf of the person)
3. The first of the following persons who is in a close and continuing relationship with the person and who, in the circumstances, is reasonably available and willing and able to make the medical treatment decision:

    (a) spouse or domestic partner of the person;

    (b) primary carer of the person;

    (c) first of the following and, if more than one person fits the description in the subparagraph, the oldest of those persons—

        (i) an adult child of the person;

        (ii) a parent of the person;

        (iii) an adult sibling of the person.

The MTDM of a child is the child's parent or guardian or other person with parental responsibility for the child.

The following are example questions you might ask your patient to determine their MTDM. Continue down the list until the person states 'yes':

- 'Do you have a legally appointed Medical Treatment Decision Maker, Power of Attorney, or VCAT Guardian?'
- 'Do you have a spouse or domestic partner?'
- 'Do you have a carer who is unpaid?'
- 'Do you have any children, which one is the oldest?'
- 'Do you have any parents?
- 'Do you have any siblings, which one is the oldest?'

Then ask:

- 'Would they be willing, available, and able to make medical treatment decisions for you?'
- 'If you were unable to speak for yourself, would you want this person to make decisions on your behalf?'

If the answer is yes, document the person's details on the ACP Summary Page (see appendix 4). If the answer is no, the person should consider appointing a MTDM. The following documents are available from the DHHS website:

- Checklist of steps for appointing your medical treatment decision maker
- Appointment of medical treatment decision maker form
- Appointment of medical treatment decision maker form (long)
- Appointment of medical treatment decision maker for someone signing on your behalf

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms

If the person does not want to list, or does not have a MTDM, the Office of Public Advocate (phone 1300 309 337) will need to be contacted to make decisions on their behalf if in the future they do not have decision-making capacity.

## Developing an Advance Care Directive

There are a number of steps required prior to completing an Advance Care Directive:

1. Encourage the person to think about what is most important to them in life based on their values and goals, use the Advance Care Planning patient information brochure (see Appendix 2) or the Instructions for completing the Advance Care Directive form (available on the DHHS website https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms ) to assist this process.
2. Discuss their values and healthcare preferences.
3. Encourage the person to talk to their family and friends about these preferences so everyone understands their choices.
4. If a person is interested in developing an Advance Care Directive, assist them to complete the documentation.

   The following documents are available from the DHHS website:

   - Advance care directive for adults
   - Advance care directive for adults for someone signing on your behalf

   https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms

## Amending existing ACP documentation or resignation of appointed person

If a person wishes to amend any of their ACP documentation (Appointment of support person, Appointment of MTDM or ACD) it is best practice to write a new document or complete a revocation form. The most recent dated document is the only valid document for a person.

- Revocation of support person form
- Revocation of medical treatment decision maker form
- Revocation of an advance care directive form

If an appointed person wishes to resign from their appointment they need to complete the appropriate form:

- Resignation of support person form
- Resignation of medical treatment decision maker form

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms

## Witnessing ACP documents

You may be asked to act as witness for a person completing:

- An Advance Care Directive

  Two adult witnesses are required, one must be a registered medical practitioner, and neither witness can be an appointed medical treatment decision maker for the person. The witnesses both need to be over the age of 18 years. Both must be present at the same time to witness the signature.

  The medical practitioner must certify that the person appears to have decision-making capacity in relation to each statement in their Advance Care Directive and that they appeared to understand the nature and effect of each statement.

  Medical practitioners are required to witness the document because of their professional skills and knowledge. Medical practitioners also have professional obligations to ensure their patients are properly informed. A medical practitioner witnessing an Advance Care Directive

should discuss the document with their patient and ensure they understand the implications of the statements made in the document and the potential outcomes if the Advance Care Directive is enacted.

- Appointment of MTDM

  Two witnesses are required. The witnesses both need to be over the age of 18 years. One witness must be someone authorised to witness affidavits or a medical practitioner (See the Department of Justice & Regulation website for a list of people authorised to witness affidavits). In addition both witnesses must not be a MTDM.

- Appointment of Support Person

  Two witnesses are required. The witnesses both need to be over the age of 18 years. One must be someone authorised to witness statutory declarations. (See the Department of Justice & Regulation website for a list of who can witness statutory declarations). Both witnesses must not be a supportive attorney under the appointment.

Witnesses must certify that the person making the appointment has decision-making capacity to do so, and that they acted freely and voluntarily.

Fact sheets for witnesses are available from the Office of the Public Advocates' website:

https://www.publicadvocate.vic.gov.au/medical-consent/information-for-witnesses

**If a person cannot physically sign the form**

If the person has decision-making capacity to make the document but cannot physically sign the form, another person can sign the form at their direction and in their presence. This person must be over the age of 18 years, not a witness and not someone being appointed. There is a specific witnessing page for this.

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms

## Alerts and storing the ACP documents

It is essential that ACP documentation can be easily identified and located if required.

Consider the following elements in your practice:

- Use practice software to record discussions and create alerts for MTDMs and ACDs
- Have an agreed processes to code ACDs within practice software so that you can search for patients with ACP documentation
- Store or file ACDs in a designated place where they can be quickly retrieved (not lost in pages of correspondence) e.g. care plans

## Communicate the ACP documents across the health sector

Certified copies are recommended to be distributed to:

1. Local hospital

   **Bendigo Health details:**

   Fax: 5454 6435 (recommended settings 9600 baud, ECM OFF)

   Email: acp@bendigohealth.org.au

   Postal address: PO Box 126, Bendigo, Vic 3552

   Phone enquiries: 5454 6386 (ACP Office)

2. Patient's MTDM and other family/friends
3. Attached to all referrals for specialist care (attached to BPAC referrals)
4. Assist the patient to create a PDF to upload their ACP into MyHealthRecord https://www.myhealthrecord.gov.au/

   As ACP documents are classified as patient 'owned' documents healthcare providers cannot upload them into the MyHealthRecord on behalf of the patient. The patient or their representative are the only legal people who can do this.

5. A certified copy for paramedics — recommended to be stored on the patient's fridge at home or with their medications
   - Ambulance Victoria supports a person's right to articulate wishes for medical treatment and care in advance through an Advance Care Directive.
   - A paramedic may provide or withhold treatment based upon the patient's wishes as recorded on an Advance Care Directive that is sighted by them or paramedics may accept, in good faith, the advice from those present at the scene of the patient's wishes and that this supporting documentation exists.
   - A patients Advance Care Directive must be followed even where the emergency is not directly related to a pre-existing illness. If the person's wishes are unknown or there is doubt about the documentation or its existence, paramedics are to provide routine care.
   - Paramedics are required to include discussions of patient's wishes and decisions in their documentation.

https://www.ambulance.vic.gov.au/wp-content/uploads/2018/07/Clinical-Practice-Guidelines-2018-Edition-1.4.pdf

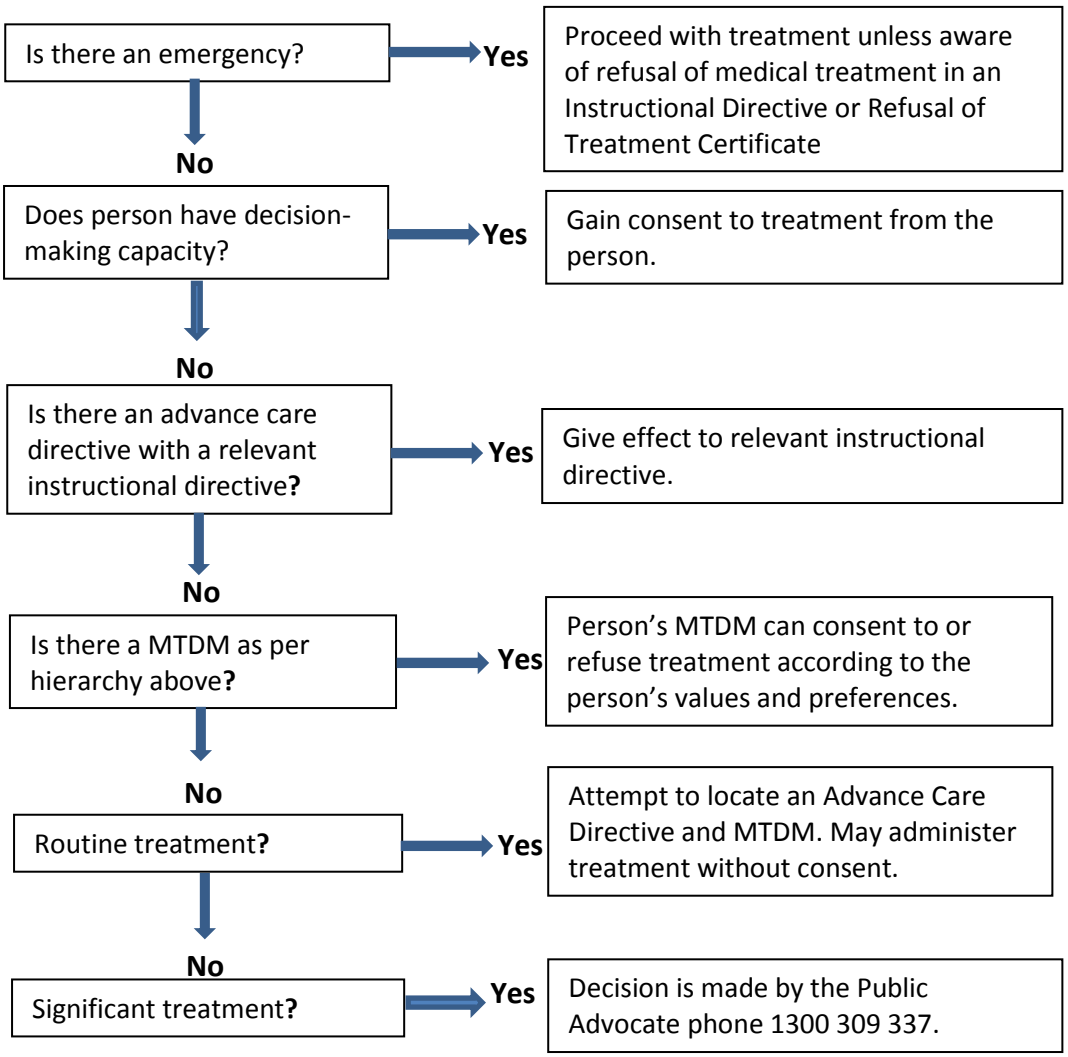
## Applying an Advance Care Directive

If a person does not have decision-making capacity, health practitioners must make reasonable efforts to locate and follow a valid Instructional Advance Care Directive e.g. Check medical files for alerts and documentation, ask their Residential Aged Care Facility or accompanying relatives if the person has an Advance Care Directive or MTDM. However a health practitioner cannot be compelled to provide particular medical treatment or futile or non-beneficial medical treatment.

If a person does not have an Instructional Advance Care Directive a health practitioner must gain consent to significant treatment from a MTDM (unless the medical treatment is an emergency). It is unprofessional conduct if a health practitioner does not fulfil this requirement. The practitioner must consider the preferences and values of the person when offering a treatment, and the MTDM must consider any previous Advance Care Planning (including a Values Advance Care Directive) to inform treatment choice.

The Medical Treatment Planning and Decisions Act 2016 applies to any treatment for a mental illness for a person without decision-making capacity who is a voluntary patient (i.e. not receiving treatment under the *Mental Health Act 2014*). Under the *Mental Health Act*, a person can appoint a Nominated Person, and develop an Advance Statement in relation to the treatment they receive. If the same person is not receiving treatment under the *Mental Health Act 2014*, the Advance Statement or an Advance Care Directive can be considered for treatment decision making.

**Figure 2: Flow chart of gaining consent**




## Review existing documents

Create reminders for ACP review:

- Patient has a hospital admission
- The patient's condition or circumstances change
- Regular time points - e.g. yearly / 2 yearly, over 75 health checks etc.

Also refer to Triggers for introducing ACP as they are also good review triggers

## Staff Education and Training

All clinical staff have the opportunity to complete the Advance Care Planning Australia e-learning course and attend ACP workshops (Bendigo Health offers regular workshops).

For more information see Advance Care Planning Australia website:

https://www.advancecareplanning.org.au/for-health-and-care-workers/workshops-and-specialised-training

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## Legislation/References/Supporting Documents:

**State and Commonwealth Legislation**
Medical Treatment Planning and Decisions Act 2016 (Vic) (commenced on the 12th March 2018)
Medical Treatment Act 1988 (Vic) Repealed 12th March 2018
Guardianship and Administration Act 1986 (Vic)
Powers of Attorney Act (Vic) 2014

**Standards / Codes of Practice / Industry Guidelines**

Advance Care Planning Australia www.advancecareplanning.org.au, ph. 1300 208 582

Department of Health and Human Services (DHHS) implementation strategy for ACP Advance Care Planning: have the conversation A strategy for Victorian health services 2014-2018.

Medical Treatment Planning and Decisions Act 2016

Office of the Public Advocate https://www.publicadvocate.vic.gov.au/medical-consent/plan-your-future-care

Significant treatment clinical guidelines for the Medical Treatment Planning and Decisions Act 2016: For health practitioners. Department of Health and Human Services. https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/medical-treatment-planning-and-decisions-act

## Authorised/Endorsed by:

Advance Care Plans across the health system in rural Victoria project Steering Committee

## Funded By:

Better Care Victoria – Innovation Projects 2017-2018

## Appendix 1. Department of Health poster and fact sheet

# Who would you trust to make your important medical treatment decisions?

If you were too sick or injured to have your say about your healthcare, **who would do it for you?**

## Speak up about your preferences today– so they will be respected tomorrow

Start **advance care planning** today:

### Appoint someone to speak on your behalf

This person will be your **medical treatment decision maker**.

They will make medical treatment decisions for you, if you are too sick to do it yourself.

They must consider any preferences you have spoken about or written down.

### Chat to your medical treatment decision maker, family and friends about what matters to you

Also talk to your doctors or other healthcare professionals about how your health needs might look in the future.

### Put it in writing in an advance care directive and have it witnessed – it's now a legal document

This can include one, or both, of the following:

- an **instructional** directive, which allows you to give consent to, or refuse, specific medical treatments
- a **values** directive, which allows you to more generally describe your preferences and values for future medical treatment.

These need to be witnessed and signed by a medical practitioner.

**Speak** to your GP or **visit** betterhealth.vic.gov.au/havetheconversation

For further information contact: (insert name)
Phone: (insert phone) Email: (insert email)

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VICTORIA State Government | Health and Human Services

## Appendix 2. Patient Information Brochure

### What is Advance Care Planning?

Advance care planning is about making your fut ure healthcare wishes known in case you are too sickto speak for yourself. It makes surethose who are looking after you know what your wishes are and what is importantto you for your healthcare.

It can help you, your loved ones and those caring for you to know what is important to you and what you want if you became unable to make your own decisions.

ACP enables the provision of healthcare based on your beliefs, values and preferences.

An ACP also helps to ensure your wishes are known and respected. This can help your family and medical team to provide quality care and can reduce unnecessary medical treatments.

Healthcare providers may ask you on admission to hospital if you have an Advance Care Plan which may include an Advance Care Directive or a Medical Treatment Decision Maker.

### Getting started

We can send you an information pack about Advance Care planning

OR

You can make an appointment to see an Advance Care Planning coordinator at the Bendigo Hospital to assist you or you can make an appointment with your local GP clinic.

### Contact the Advance Care Planning Team for more information

Phone: 03 5454 6386

Email: acp@bendigohealth.org.au

Bendigo Hospital
Advance Care Planning Coordinator
PO Box 126
Bendigo VIC 3552

Forms and guides are available for download from the Bendigo Health website www.bendigohealth.org.au

# Advance Care Planning

## Planning your future healthcare

BENDIGO HEALTH Excellent Care. Every Person. Every Time.

# What if you got too sick to speak for yourself?
# Who would make medical decisions for you? Do they know what you want?
# Planning ahead for your medical needs is called Advance Care Planning and makes everyone aware of your healthcare wishes.

## ADVANCE

### A. Appoint

Did you know if you come to hospital and are unable to make your own decisions, there is a list governed by law to tell healthcare providers who to call.

If you want to choose your own medical treatment decision maker (MTDM) you can sign a legal form to make sure everyone knows who can make medical decisions on your behalf if you are too unwell to speak for yourself.

## CARE

### C. Chat & Communicate

Think about your own values, beliefs and wishes for your future healthcare.

Have a conversation with your family, friends, caregivers and doctors about your healthcare preferences.

Tell them what is important to you and what matters the most about your current and future healthcare.

## PLANNING

### P. Put it on paper

Write down your preferences in an Advance Care Directive . This form is available from the hospital or the Department of Health website and can be filled out with the help of a healthcare professional.

This helps guide others in making medical decisions if you are unable to make them yourself.

You can update, review or cancel your Advance Care Directive at any time.

It is recommended to review your plan every 1-2 years.

You can share your Advance Care Directive with your local hospital, GP, Medical Treatment Decision Maker and family. You can also upload it to My Health Record.

# Medical Treatment Planning and Decisions Act 2016 documents –

# DHHS templates

Please note: these documents may not be the latest versions – please see the Department of Human Services ACP forms page:

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms

The *Medical Treatment Planning and Decisions Act 2016* enshrines advance care directives in Victorian law and creates clear obligations for health practitioners caring for people who do not have decision-making capacity.

To give Victorians confidence that their decisions about medical treatment will be respected, the Department of Health and Human Services has created the standard forms below, which allow Victorians to:

- Make an advance care directive which can include an instructional directive (which will provide specific directives about treatment a person consents to or refuses) and/or a values directive (which will describe a person's views and values).
- Appoint a medical treatment decision maker (who will make decisions on behalf of a person when they no longer have decision making capacity).
- Appoint a support person (who will assist a person to make decisions for themselves, by collecting and interpreting information or assisting the person to communicate their decisions).

**All forms under the Medical Treatment Planning and Decisions Act 2016 are available to download free of charge and may be completed without seeking legal advice or assistance.**

## Advance care directive

1. **Advance care directive for adults:** this document allows an adult to document their preferences for future medical treatment, should they lose decision-making capacity. A person can record general statements about their values and preferences to guide future medical treatment decisions, or record instructions consenting to or refusing specific types of treatment.
2. **Instructions for completing the Advance care directive form:** these instructions providing additional guidance and information to assist in completing the Advance care directive for adults form.
3. **Advance care directive for adults for someone signing on your behalf:** use this form if you need someone to fill in and sign an advance care directive for you, at your direction. This document allows an adult to document their preferences for future medical treatment, should they lose decision-making capacity. A person can record general statements about their values and preferences to guide future medical treatment decisions, or record instructions consenting to or refusing specific types of treatment.
4. **Revocation of an advance care directive form:** use this form to revoke a previously completed advance care directive.
5. **Advance care directive for young people under 18 years of age:** this document allows a young person under 18 years of age to document their preferences for future medical

treatment, should they lose decision-making capacity. A person can record general statements about their values and preferences to guide future medical treatment decisions, or record instructions consenting to or refusing specific types of treatment.

6. **Information for clinicians working with young people under 18 years of age:** this form provides additional guidance and information for clinicians working with young people under 18 years of age.
7. **Instructions for completing Advance care directive for young people under 18 years of age form:** these instructions providing additional guidance and information to assist in completing the Advance care directive for young people under 18 years of age.

## Medical treatment decision maker

8. **Appointment of medical treatment decision maker form:** this document allows you to formally appoint a medical treatment decision maker, who will have legal authority to make medical treatment decisions on your behalf, should you become unable to do so.
9. **Checklist of steps for appointing your medical treatment decision maker:** this checklist provides additional guidance and information to help you appoint your medical treatment decision maker.
10. **Appointment of medical treatment decision maker form (long):** use this document if you wish to formally appoint multiple medical treatment decision makers, who will have legal authority (in order of appointment based on availability at the time), to make medical treatment decisions on your behalf, should you become unable to do so.
11. **Appointment of medical treatment decision maker for someone signing on your behalf:** use this document if you need someone to fill in and sign an appointment of medical treatment decision maker form for you, at your direction. This document allows you to formally appoint a medical treatment decision maker, who will have legal authority to make medical treatment decisions on your behalf, should you become unable to do so.
12. **Revocation of medical treatment decision maker form:** use this form to revoke your appointment of a medical treatment decision maker.
13. **Resignation of medical treatment decision maker form:** use this form to resign from being a person's appointed medical treatment decision maker.

## Support person

14. **Appointment of support person form:** this form allows you to appoint a support person to assist you to make, communicate and give effect to your medical treatment decisions.
15. **Checklist of steps for appointing your support person (medical treatment):** this checklist provides additional guidance and information to help you appoint your support person.
16. **Appointment of support person for someone signing on your behalf:** use this document if you need someone to fill in and sign an appointment of support person form for you, at your direction. This form allows you to appoint a support person to assist you to make, communicate and give effect to your medical treatment decisions.
17. **Revocation of support person form:** use this form to revoke your appointment of a support person (medical treatment).
18. **Resignation of support person form:** use this form to resign from being a person's appointed support person (medical treatment).

## Appendix 4. ACP Summary Page

| Advance Care Plan Summary page | Surname _____ UR No:_____<br>Given Names _____<br>DOB _____ Sex _____<br>Admission Date _____<br>Consultant _____ Ward _____<br>USE LABEL IF AVAILABLE |
|---|---|

ADVANCE CARE PLAN – SUMMARY PAGE

Name:_____

Address: _____

Date of Birth: _____ Telephone: _____

**Name of Support person (if formally appointed)** _____
(If yes please attach copy)
Telephone no.: _____ (Home)
_____ (Mobile)
_____ (Work)
Relationship: _____

**Medical treatment decision maker/s formally appointed** **Yes/No**
If yes please attach copy (preferably certified).
If no please determine the Medical treatment decision maker/s from the hierarchy on the next page and document below.
Patient's signs they have had the discussion about their Medical treatment decision maker and are happy with those listed below as determined by the hierarchy:

_____
*(Patient signs here)*

**Name of Medical treatment decision maker 1:** _____
Telephone no.: _____ (Home)
_____ (Mobile)
_____ (Work)
Relationship: _____

**Name of Medical treatment decision maker 2:** _____
Telephone no.: _____ (Home)
_____ (Mobile)
_____ (Work)
Relationship: _____

Optional:
**Name of Medical treatment decision maker 3:** _____
**Name of Medical treatment decision maker 4:** _____

**Advance Care Plan includes the following documents:**

1. **Medical treatment decision maker** **Yes / No**
   (This may be a Medical Enduring Power of Attorney, Enduring Power of Attorney for personal matters prior to 12th March 2018 or Enduring Guardianship prior to 1st Sep 2015)

2. **Advance Care Directive**
   a. **Values directive** **Yes / No**
   b. **Instructional directive** **Yes / No**

3. **Refusal of Treatment Certificate (written prior to March 12th 2018)** **Yes / No**

| Advance Care Plan<br>Summary page | Surname _____ UR No:_____<br>Given Names _____<br>DOB _____ Sex _____<br>Admission Date _____<br>Consultant _____ Ward _____<br>USE LABEL IF AVAILABLE |
|---|---|

ADVANCE CARE PLAN SUMMARY PAGE

**The original of this Advance Care Plan is held by:** _____

**Certified copies of your Advance Care Plan have been given to:**
(complete as many lines as applicable)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

**Medical treatment decision maker hierarchy:**

- an appointed Medical Treatment Decision Maker
- a guardian appointed by VCAT to make decisions in regard to health care
- spouse or domestic partner
- primary carer
- adult child
- parent
- adult sibling
- for a child, the parent or guardian

**Recommendations:**

- Please keep your original 'Appointment of medical treatment decision maker' form and 'Advance care directive' safe and accessible for when it is needed.
- Review your advance care directive and/or appointments every two years, or whenever there is a change in your personal or medical situation.
- Ensure that your medical treatment decision maker has read and understood the contents of your advance care directive (if any).
- Your 'Appointment of medical treatment decision maker' form and advance care directive can be uploaded on MyHealth Record and should be shared with your medical treatment decision maker and relevant health practitioner(s).
  I request that my Advance Care Plan (including my Advance Care Directive and Medical Treatment Decision Maker information) be uploaded to my MyHealth Record by: _____
  *(Healthcare provider's details)*
  Signed: _____
  *(Patient's signature)*

## Appendix 5. Location and Responsibilities of Advance Care Planning

**Senior clinicians and managers**

- Support ACP
- Incorporate into core business
- Encourage staff to attend training

**Clerical Staff:**

- Clerical Staff will update the Medical Treatment Decision Maker or Support Person for all patients.
- Clerical staff will scan and file in the electronic medical record all ACP documentation.
- Clerical staff will communicate the ACP documentation with other relevant healthcare organisations

**Nurses:**

- On initial assessment: check the appropriate Medical Treatment Decision Maker is listed, ask if the patient has any Advance Care Planning documents.
- Check the documents are in the Medical Record, if not, ask for a copy from the patient, patient's family.
- The nurse must check there is a corresponding Advance Care Planning alert
- If the patient does not have an Advance Care Directive, the nurse will introduce Advance Care Planning to the patient and provide them with a brochure as appropriate
- Any further discussions regarding a patient's values or goals for now and in the future, or acceptable or unacceptable outcomes can be documented electronically as a Discussion Record

**Allied Health:**

- Check if the person's appropriate Medical Treatment Decision Maker is listed.
- If patients discuss values, goals for now and the future, or acceptable or unacceptable outcomes, these should be documented in a Discussion Record in an Advance Care Planning alert.

**Doctors: (as appropriate)**

- On initial assessment, discuss the patient's knowledge of conditions and goals of care, confirm the MTDM and if there are ACP documents.
- If the patient declines discussing their goals of care, ensure the patient understands this can be discussed in the future, and leave a brochure with the patient.
- When a patient does not have decision-making capacity, doctors will gain consent from the MTDM and use ACP documents to inform their treatment decisions.

**Advance Care Planning Champion:**

It is advised that clinics will nominate1-2 senior clinicians who are passionate about person-centered care to lead the implementation of Advance Care Planning in their team/unit.

Qualities:

- Has completed the ACP education modules and participates in face-to-face education
- Can create an ACD and put in an ACP alert unsupervised
- Has effective communication
- Perceives and understands clinical or social situations as whole parts in the ACP process
- Holistic understanding of ACP to enable effective decision-making
- Learns from experiences in ACP and can modify interactions as appropriate

Responsibilities

- Ensure data is monitored at team meetings, and presented
- Ensure ACP alerts are entered appropriately on ward or team
- Perform an annual quality audit for ACP
- Supervises novices and beginners ACP
- Advises clinicians on how to implement an ACD
- Participates in ACP education opportunities

**Multidisciplinary Opportunities for ACP:**

- Multidisciplinary team meetings are an opportunity for clinicians to discuss and document the patient's values and goals for now and the future and document electronically. It is also an opportunity to discuss the patient's ACD if they are not competent, and ensure treatment decisions align with the patient's values.
- ACP should be included on any templates created for multidisciplinary discussions to ensure the patient's values are known, and guide treatment decisions.
- ACP should be included in Position Descriptions for all clinical staff to embed ACP in the organisation.

## Appendix 6. Quick Reference Guide

# Advance care planning process in general practice

(This document is designed to be used in conjunction with the ACP General Practice Guidelines)

### 1. Does the patient have existing ACP documentation?

NO → 

YES → Ask for a copy of their documents

### 2. Is the patient competent to participate in ACP?

YES → 

NO → Complete Step 3. then stop (If the answer is No refer to OPA)

### 3. Is the person in the patient's MTDM hierarchy appropriate?

NO → 

YES → Record their details on the ACP Summary page or in your clinical system

### 4. Does the person want to complete ACP documentation?

NO → Document the patient's choice to decline ACP for future reference

YES → Download forms: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms

### 5. Storing the plan

Use practice software to record discussions and create alerts

Keep a certified copy in the patient's file—if files are electronic scan it to create a PDF (see below "Communicating the Plan")

Have an agreed processes to code ACDs within practice software so that you can search for patients with an ACD

Store or file ACDs in a designated place – e.g. care plans

### 6. Communicating the plan

Certified copies are recommended to be distributed to:

1. Local hospital
2. Patient's MTDM and other family/friends
3. With all referrals for specialist care
4. Assist the patient to create a PDF to upload their ACP into MyHealthRecord https://www.myhealthrecord.gov.au/
5. A certified copy for paramedics — recommended to be stored on the patient's fridge at home or with their medications

### ACP documentation includes evidence of their:

1. MTDM (including previous MEPOAs, POA for personal matters, Guardianship see Note** below)
2. Advance Care Directive

Ensure the documents are valid.

### Decision-making capacity

The patient is able to understand the information relevant to the decision, retain the information to the extent necessary to make the decision, use or weigh that information as part of the process of making the decision, and communicate their decision in some way.

Sometimes a relevant specialist may be required to make a capacity assessment.

### Medical treatment decision maker list

The first person, 18 years of age or older, in the list below, is the patient's medical treatment decision maker. They must be reasonably available and willing and able to make the decision.

1. An appointed medical treatment decision maker
2. A guardian appointed by VCAT to make decisions about the patient's medical treatment
3. The first person in the list below who is in a close and continuing relationship with the patient:
   a. spouse or domestic partner
   b. primary carer (not a paid service provider)
   c. adult child
   d. parent
   e. adult sibling.

If there are two or more relatives who are first on this list, it is the eldest person.

### Witnessing documents

For more information and factsheets: http://www.publicadvocate.vic.gov.au/medical-consent/information-for-witnesses

| ACD | Appointment of MTDM and support person |
|---|---|
| For an advance care directive, two adult witnesses are required.<br><br>One must be a registered medical practitioner.<br><br>Neither witness can be an appointed medical treatment decision maker for the person. | For an appointment of medical treatment decision maker, two adult witnesses are required.<br><br>One must be a registered medical practitioner or authorised to witness affidavits.<br><br>See the Department of Justice & Regulation website for a list of people authorised to witness affidavits.<br><br>Neither witness can be a person who is being appointed in the document. |

### Remember the patient owns these documents

Ensure all original documents are returned to the patient once completed and copied as per storing and communicating the plan.

Do not under any circumstances destroy any original documentation.

### Local hospital contact details:

**Bendigo Health**

E-mail: acp@bendigohealth.org.au

Fax: 5454 6435

(Recommended setting 9600 baud, ECM OFF)

Postal address:
PO Box 126
Bendigo
Vic 3552

**Note: Before the Medical Treatment Planning and Decisions Act commenced in 2018, patients may have appointed someone to make their medical treatment decisions in a medical enduring power of attorney, an enduring power of attorney, or enduring power of guardianship. These appointments are still valid.

# Medical Treatment Planning and Decisions Act 2016 - Overview

## Health practitioners need a patient's consent before providing medical treatment.

The Medical Treatment Planning and Decision Act 2016 commenced on 12th March 2018. It set out steps for health practitioners to follow when a patient is unable to consent.

## The Act applies to all health practitioners

The Act applies to all registered health practitioners in the following professions:

- Medical
- Dental
- Physiotherapy
- Occupational therapy
- Chiropractic
- Pharmacy
- Optometry
- Psychology
- Nursing and midwifery
- Medical radiation practice
- Osteopathy
- Chinese medicine
- Aboriginal and Torres Strait Islander health practice

In addition, the Act applies to the following, who are also health practitioners under the Act:

- Paramedics
- Non-emergency patient transport staff.

## Medical treatment

Medical treatment is treatment by a health practitioner that is for one or more of the purposes and one of the forms of treatment listed below.

| Purpose | Treatment |
|---|---|
| • Diagnosing a physical or mental condition<br>• Preventing disease<br>• Restoring or replacing bodily function in the face of disease or injury<br>• Improving comfort and quality of life | • Treatment with physical or surgical therapy<br>• Treatment for mental illness<br>• Treatment with<br>- prescription pharmaceuticals<br>- an approved medicinal cannabis product<br>• Dental treatment<br>• Palliative care |

## Emergency treatment

**Consent is not needed in an emergency.**

Emergency treatment must not proceed if the health practitioner is aware that the patient has refused the particular treatment in an instructional directive (one kind of advance care directive), or there is a relevant refusal of medical treatment certificate made before 12th March 2018.

In an emergency, a health practitioner is not required to search for an advance care directive that is not readily available.

## Record-keeping

A health practitioner needs to record on the patient's clinical records the reasons they were satisfied the patient did not have decision-making capacity.

## MBS items that support ACP

There is no dedicated MBS item for ACP however several MBS items can support ACP as part of other health interventions.

https://nwmphn.org.au/page/2/?s=Advance+Care+Planning

## Palliative care

A health practitioner is able to administer palliative care to a patient who does not have decision-making capacity for that care, despite any decision of their medical treatment decision maker (or any statement in an advance care directive). However, the health practitioner must have regard to the patient's expressed preferences and values and must consult with their medical treatment decision maker, if any.

## Futile treatment

Health practitioners assess whether or not to offer a particular medical treatment, and whether a particular treatment is futile or non-beneficial.

## Significant and routine treatment

A health practitioner must seek consent from the Public Advocate to provide significant treatment to a patient who:

- does not have decision making capacity for the medical treatment decision and
- does not have:
  - a medical treatment decision maker or
  - an advance care directive with a relevant instructional directive.

Significant treatment means any medical treatment of a patient that involves any of the following:

- A significant degree of bodily intrusion
- A significant risk to the patient
- Significant side effects
- Significant distress to the patient

For Clinical Guidelines about what constitutes significant treatment https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/medical-treatment-planning-and-decisions-act

Routine treatment is any treatment that is not significant treatment under the Act. A health practitioner can administer routine treatment without consent if there is no medical treatment decision maker. If they do so, the health practitioner will need to set out in the patient's clinical records the details of:

- The health practitioners attempts to locate an advance care directive and a medical treatment decision maker
- The exact nature of the routine treatment and the reason for the decision to administer it.

## Notifications to the Public Advocate

A health practitioner must notify the Public Advocate if:

- The medical treatment decision maker of a patient refuses significant treatment and
- The heath practitioner reasonably believes that the preferences and values of the patient are not known, or are unable to be known or inferred.

**The health practitioner then awaits the response of the Public Advocate.**

## More information

For more information about the Medical Treatment Planning and Decisions Act, visit the OPA website at:
www.publicadvocate.vic.gov.au